DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH
Office of Narcotics and Dangerous Drugs
Phone 302-744-4547

BIENNIAL REGISTRATION/RENEWAL APPLICATION FOR ADVANCED PRACTICE NURSES CONTROLLED SUBSTANCE PRESCRIPTIVE AUTHORITY

(For Office of Narcotics and Dangerous Drugs Use Only):

License No.	Renewal Date	Amt. Rec'd.	Check No.	Date Rec'd.

PLEASE PRINT OR TYPE

Section A - PERSONAL DATA (Do not use a post office box address)

1-A. Applicant's Name and Practice Address

1-B Name and Home Address

2. Date of Birth_____ 3. Home Phone_____ 4. Work Phone_____

5. Driver's License Number_____State_____ 6. Social Security Number_____

7. Advanced Practice Nurse License No._____Expiration Date_____

8. Prescriber I.D. No.: RXAPN_____ 9. Area of Specialty_____

10. Federal DEA #_____

Section B - DISCLOSURES

1. ☐ Yes ☐No Has the applicant ever been convicted of a crime in connection with controlled substances under State or Federal law?

2. ☐ Yes ☐ NoHas the applicant ever surrendered or had a Federal controlled substances registration revoked, suspended, restricted, or denied?

3. ☐ Yes ☐ No Has the applicant ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

4. ☐ Yes ☐ No If the applicant is a corporation (other than a corporation whose stock is owned and traded by the public), association, partnership, or pharmacy, has any officer, partner, stockholder or proprietor been convicted of a crime in connection with controlled substances under State or Federal law, or ever been suspended, restricted or denied, or ever had a State professional license or controlled substances registration revoked, suspended, denied, restricted, or placed on probation?

* If the answer to any of the above questions is yes, please attach a letter setting forth the circumstances of such action.

Section C **- SCHEDULES REQUESTED**

Registration is requested in the following schedules: ☐ **II** ☐ **III** ☐ **IV** ☐ **V**

Section D **- PRACTICE DATA**

1. * Name of Collaborator: _____

Business Address of Practice: _____

_____

Telephone Number _____

A Collaborative Agreement with the applicant has been established. I am aware that this application is for a CSA Number in the State of Delaware, and if approved, the applicant will be able to prescribe drugs in the Schedules checked in Section C of this form provided that he/she obtains a DEA number.

_____ _____
(Authorized Signature) **(Date)**

_____
Name (typed or printed)

*** If more than one collaborative agreement has been established, please provide same information on additional sheets.**

Section E - CERTIFICATION

I certify that the facts stated in this application are true, complete and correct and that this application is made to obtain biennial registration, pursuant to the Uniform Controlled Substances Act. I will notify the Office of Narcotics and Dangerous Drugs in writing within 10 days of all changes pertaining to personal data in Section A and practice data in Section D.

MAIL APPLICATION TO: ******** **Fee: $40.00** **(Make Check Payable to "State of Delaware")**

NARCOTICS & DANGEROUS DRUGS
JESSE COOPER BLDG ROOM 205
417 FEDERAL STREET
DOVER, DE 19901

_____ _____
(Signature) ***(Date)***

_____
Name (typed or printed)

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FOR STATE USE ONLY: Verification with the Delaware Board of Nursing: Name _____

ONDD Personnel Name: _____ **Date** _____

35-05-20/01/10/25